STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE:

Fernwood Rest Home, Inc. of Litchfield, CT
d/b/a Fernwood Rest Home, Inc.
400 Torrington Road
Litchfield, CT 06759

CONSENT ORDER

WHEREAS, Fernwood Rest Home, Inc. of Litchfield, CT d/b/a Fernwood Rest Home, Inc. ("Licensee" or "Facility"), has been issued License No. 1699-RCH to operate a residential care home known under Connecticut General Statutes section 19a-490 by the Connecticut Department of Public Health ("Department"); and,

WHEREAS, the Facility Licensing and Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates which concluded November 21, 2012; and,

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated December 3, 2012 (Exhibit A – copy attached); and,

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, its Section Chief, and the Licensee, acting herein and through Raymond Adkins, its President hereby stipulate and agree as follows:

1. The Licensee shall enter into a contract with a Temporary Manager pre-approved by the Department within eight (8) business days of the effective date of this Consent Order. The terms of the contract executed with the Temporary Manager

shall include all pertinent provisions contained in this Consent Order. The Temporary Manager's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur all costs associated with the hiring of the Temporary Manager. The Licensee shall provide the Department with a signed copy of the contract within twenty-four (24) hours of its execution.

2. The Temporary Manager shall be physically present at the Facility at least forty (40) hours per week unless the Department approves otherwise based upon a request from the Temporary Manager. The Temporary Manager shall arrange his/her schedule in order to be present at the Facility at various times during all operational hours including holidays and weekends. Upon the effective date of this Consent Order, Vivian Adkins shall no longer be the Person-in-Charge of the Facility. The Temporary Manager shall serve in this capacity for at least a period of six (6) weeks and at least until a new, permanent full-time Person-in-Charge, approved by the Department, has been hired. After the Temporary Manager is replaced by a new, permanent full-time Person-in-Charge who has been approved by the Department, the Temporary Manager shall serve as a Consultant to the Facility for a period of four (4) weeks. During the four week period, the Consultant shall be present at the facility at least twenty (20) hours per week, and shall make recommendations to the Person-in-Charge. Such recommendations shall also be sent to DPH. On behalf of the Facility, within ten days of receipt of the recommendations of the Consultant, the Person-in-Charge shall review and respond in writing to the recommendations of the Consultant. Such response shall also be sent to the Department.
3. The Temporary Manager shall act and perform the duties assigned herein at all times in assuring the safety, welfare and well-being of the residents and to secure compliance with applicable state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
4. The Temporary Manager shall oversee corrections of non-compliance with state laws to assure the health and safety of the residents served.

5. The Temporary Manager, with the approval of the Department, shall be responsible for recruiting and replacing the permanent appointments of the following full time positions:
    a. Person In Charge.
6. The Temporary Manager shall conduct a comprehensive review of the staffing at the Facility. Such review shall identify vacant positions that are not filled and shall identify staffing needs. The Temporary Manager shall ensure that all vacant positions are filled/refilled to ensure adequate and qualified staff is on site to meet the needs of the residents served. Active recruitment efforts shall be initiated to ensure that all vacant positions are filled/refilled.
7. The Temporary Manager shall have the authority to hire, terminate or reassign staff; obligate facility funds; alter, develop and implement facility policy and procedures; and otherwise manage the facility. The Temporary Manager shall be provided full access to and management of all the facility bank accounts and/or internal controls related to billing/accounts receivable, cash receipts, accounts payable, cash disbursements, and payroll records. The Temporary Manager shall have access to all areas of the facility at all times, seven days a week and twenty-four hours per day. The Licensee agrees to provide to the Temporary Manager all security codes, maintenance records, contracts and leases and any other documents the Temporary Manager requests. The Licensee agrees to cooperate with the Temporary Manager in all respects. The Temporary Manager shall be compensated by the Licensee at a rate agreed upon by the Temporary Manager and the Licensee.
8. The Temporary Manager shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the residents and to secure compliance with applicable state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
9. The Temporary Manager shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within four (4) weeks after the execution of this Consent Order.

10. The Temporary Manager shall confer with all staff determined by the Temporary Manager to be necessary to the assessment of resident services and the Licensee's compliance with state statutes and regulations.
11. The Temporary Manager shall make recommendations to the Licensee for improvement in the delivery of resident care in the facility. If the Temporary Manager and the Licensee are unable to reach an agreement regarding the Temporary Manager's recommendation(s), the Department, after meeting with the Licensee and the Temporary Manager, in it sole and absolute discretion, shall make a final determination, which shall be binding on the Licensee.
12. The Temporary Manager shall submit written reports monthly to the Department documenting:
    a. The Temporary Manager's assessment of the care and services provided to residents;
    b. The Licensee's compliance with applicable state statutes and regulations; and
    c. Any recommendations made by the Temporary Manager and the Licensee's response to implementation of the recommendations.
13. Copies of all Temporary Manager reports shall be simultaneously provided to the Licensee and the Department.
14. The Temporary Manager shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on resident rights, nutritional services, resident smoking, management of personal funds, and medication administration;
    b. Assessing, monitoring, and evaluating the coordination of resident care and services provided and delivered;
    c. Recommending to the Department an increase or decrease in the Temporary Manager's contract hours if the Temporary Manager is unable to fulfill the responsibilities within the stipulated hours per week or if hours are in excess of what the Temporary Manager deems necessary; and

d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated December 3, 2012 (Exhibit A).

15. The Licensee and the Temporary Manager shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at twelve (12) week intervals throughout the tenure of the Temporary Manager. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable state statutes and regulations.
16. Any records maintained in accordance with any state law or regulation or as required by this Consent Order shall be made available to the Temporary Manager and the Department, upon request.
17. The Department shall retain the authority to extend the period the Temporary Manager functions are required should the Department determine that the Licensee is not able to maintain substantial compliance with state laws and regulations. Determination of substantial compliance with state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department and on any other information the Department deems relevant. The Licensee understands that it does not have a right to a hearing on any determination made pursuant to this paragraph.
18. Within thirty (30) days of the execution of this Consent Order the Licensee shall develop and/or review and revise, as necessary, policies and procedures related to continuing education for staff, resident rights, nutritional services, resident smoking, management of personal funds, and medication administration.
19. Within ten (10) business days of the revisions of the policies set forth above, all Facility shall be in-serviced on the policies and procedures identified in paragraph number eighteen (18).
20. Within twenty-one (21) days of the effect of this Consent Order, the Licensee shall ensure that a Resident Council has been established, free from administrative interference or reprisal and is provided a meeting space and the opportunity to meet with regularity, as determined by the resident council.
21. Effective upon the execution of this Consent Order, the Licensee, shall ensure substantial compliance with the following:

a. Sufficient personnel are available to meet the needs of the residents;
b. Residents shall be free from abuse, neglect, intimidation, retaliation and misappropriation of property;
c. Resident rights;
d. Residents shall be provided diets in accordance with physician orders;
e. Staff orientation upon hire;
f. Residents shall be provided with quarterly statements;
g. Continuing annual education for all facility staff to include but not be limited to, emergency procedures, resident rights, behavioral management, personal care, resident safety and nutrition;
h. Residents shall be provided nutritional offerings, including snacks that are nutritious and provide variety;
i. Medication administration;
j. Maintain documentation for narcotic reconciliation in accordance with state laws and regulations;
k. Management of resident personal funds; and
l. Provide an environment that is free from accidents and hazards.

22. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.

23. The Licensee shall pay a civil penalty to the Department in the amount of two thousand dollars ($2,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and delivered to the Department at the time of the signing of this Consent Order. The civil penalty and any reports required by this Consent Order shall be directed to:

Maureen Klett, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

24. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing

herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

25. The allegations and/or violations contained in Exhibit A shall be deemed true in any subsequent proceeding before the Department in which the Licensee's compliance with this Consent Order or the Connecticut General Statutes or Regulations of Connecticut State Agencies is at issue.
26. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
27. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
28. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
29. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the December 3, 2012 violation letter referenced in this Consent Order.

30. The Licensee has consulted with its attorney prior to the execution of this Consent Order.

**

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

By: Raymond H Adkins Pres.
Raymond Adkins, President
Fernwood Rest Home, Inc.

On this the 25th day of February, 2013, before me, personally appeared Raymond Adkins, who acknowledged himself to be the President of Fernwood Rest Home, Inc. and that he, as such President being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the Licensee by himself as their President.

My Commission Expires: _____
(If Notary Public)

Karyn A. Cosgrove
Notary Public [ ]
Commissioner of the Superior Court [ ]

KARYN A. COSGROVE
NOTARY PUBLIC
MY COMMISSION EXPIRES APR. 30, 2017

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

~~February~~ March 5, 2013

By: Barbara Cass
Barbara Cass, R.N., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Exhibit A

December 3, 2012

Vivian Adkins, Person In Charge
Fernwood Rest Home Inc
Torrington Road, Po Box 548
Litchfield, CT 06759

Dear Ms. Adkins:

Unannounced visits were made to Fernwood Rest Home Inc on November 21, 2012 by representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled on December 18, 2012 at 1:30 PM in the facility Licensing and Investigations Section of the Department of Public Health , 410 Capitol Avenue, Second Floor, Hartford, Connecticut. It is expected that you and Karen Cosgrove will attend this meeting. Should you wish to retain an legal represnetation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 17, 2012 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advisied that the preparation of a Plan of correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by menas of a Consent Order.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Maureen H. Klett, RN

Maureen H. Klett, R.N.,C. , M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: November 19, 20, and 21, 2012

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4) and/or (f) Dietary Services (1)(2).

1. Based on review of medical records, interviews with staff/residents and observations, the facility failed to ensure that the resident's dietary needs were followed and/or staff had training related to the resident's dietary needs. The findings include:

   a. Resident #1's had physician orders dated 8/8/12 identified that the resident was on a low salt/low cholesterol diet. Review of the kitchen diet log failed to have the resident listed as being on a special diet until surveyor inquiry on 11/20/12.

   b. Resident #2 had physician orders dated 11/19/12 identified that the resident was on a 1500 calorie diet. Review of the kitchen diet log failed to have the resident listed as being on a special diet.

   c. Resident #3 had physician orders dated 11/19/12 identifying that the resident was on a regular diet, however, the resident had a diagnosis of Phenylketonuria diet. Although the resident was listed on the kitchen diet log, the resident had not received the diet as ordered. Observation of the resident's breakfast tray on 11/20/12 identified that the resident had received eggs which is a restricted item. Interview with Staff on 11/22/12 identified that staff members were buying food for the resident and bringing it into facility so that the resident's dietary needs were being meet.

   d. Resident #5 had physician orders dated 11/19/12 identifying that the resident was on a 2000 calorie diabetic diet. Review of the kitchen diet log failed to have the resident listed as being on a special diet.

   e. Review of resident menus from 1/2012-11/2012 identified that residents were only given eggs two days a week and hot/cold cereal five days a week and donuts on Sunday. Further review failed to identify that any other breakfast items were provided to residents.

   f. Interviews with multiple residents on 11/19-11/21/12 identified that they are only provided with a peanut butter and jelly sandwich as an alternative meal. Interview with staff members on 11/20/12 identified that the residents are only offered a peanut butter and jelly sandwich by some of the dietary staff, however, at times they are given leftovers as an alternative meal.

   g. Interviews with multiple residents on 11/19-11/21/12 identified that they are only given a granola bar for snack time with some residents indicating that they are still hungry and are told they cannot have any other snacks until the next day.

   h. Interview with the Day Shift Dietary Manager on 11/20/12 identified that he does not have a list of the residents with special diet needs including diabetic residents and/or policy regarding special diets for residents.

   i. Interviews with staff members on 11/20-11/21/12 identified that they have not received any training related to resident's special diets. Interview with the Administrator on 11/21/12 identified that staff

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

had not received training related to the resident's special dietary needs.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5) and/or (h) General Conditions (2).

2. Based on review of the clinical record, interviews with facility staff and residents and observations, the facility failed to ensure that residents were treated with respect and dignity by administration and/or provided with privacy with opening the resident's mail. The findings include:

a. Interview with multiple residents on 11/19-11/21/12 identified that staff do not treat them with respect and dignity. Further interviews identified that administration staff have told residents that they have to "go shopping to feed the monkeys" and have stated that they put a chain across dining room area to "keep the monkeys out." Interview with a facility staff member on 11/20/12 identified that the Administration staff do not treat the residents with respect and that the Administration staff do put a chain across the dining room so no resident can go in dining room when staff are making a gourmet breakfast for themselves. Further interview on 11/20/12 identified that they are "to keep monkeys out" of the dining room when the staff are having breakfast.

b. Resident #1 indicated on 11/20/12 that she was told that she had to sign and agree to being reprimanded by administration. Interview with the administrator on 11/20/12 identified that the residents are required to sign the resident agreement and may be reprimanded for not following the facility rules. Review of facilities resident agreement indicated that reprimands will be given for failure to comply with rules involving safety, security, and /or the peace of our home.

c. Resident #1 indicated that over the summer she was not allowed to wear a sundress in the dining room. Interview with the Administrator on 11/20/12 identified that residents are not allowed to wear certain clothing for mealtime. Review of facility policy indicated that resident's agree to wear clothing that is appropriate for the season.

d. Interviews with multiple residents on 11/19/12-11/21/12 indicated that they have no privacy with opening their mail and/or packages. In addition, multiple residents indicated that their mail is already opened by Administration before they get it. Interview with Resident #1 on 11/19/12 identified that she was forced to open a package with a cell phone in front of the Administrator and had no privacy.

e. Observation of LPN # 2 on 11/21/12 at 5:45am identified that the nurse was calling an attendant to the nurses' station. Further observation identified that the residents were still sleeping at that time and were being woken up by the intercom system. Interview with multiple residents on 11/20/12 identified that they are told by Administration that they have to get up and dressed by 7:00am for breakfast.

DATE(S) OF VISIT: November 19, 20, and 21, 2012

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5).

3. Based on review of the clinical record, interviews with facility staff and residents and observations, the facility failed to ensure that residents were safe with smoking practices. The findings include:

   a. Observation of the smoking area on 11/19/12 identified that multiple metal gallon food cans were being used to put out smoking materials including using the same receptacles for throwing out garbage, including paper plates and cups. Further observation on 11/19/12 identified that smoke was coming out of one of the metal cans while the residents were smoking.

   b. On 4/4/12, Resident #4 was seen by a roommate holding a lighter to the smoke alarm and then tried to light some papers to see if it was working.

   c. Interview with the Administrator on 11/20/12 identified that a few days ago, Resident #4 was also found to have a plastic cup in his room with burn holes in it. Further interview with the Administrator on 11/20/12 identified that there was no plan in place on supervising Resident #4 for unsafe smoking.

   d. Review of facility smoking policy identified that staff is to monitor smokers for changes in mental/physical status and compliance with smoking rules to determine if they should continue with smoking privileges. In addition, any resident found smoking in the building will lose said privileges and will be added to the smoking restriction list.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5).

4. Based on review of facility documentation and interviews with facility personnel, the facility failed to ensure that residents were given quarterly statements and/or receipts for any items that are purchased on behalf of the resident. The findings include:

   a. Interview with multiple residents on 11/20/12 identified that they are not allowed to manage their own personal accounts. In addition, the residents state that they have never received quarterly statements and/or have an interest bearing account related to their personal accounts. Further interview identified that the residents are asked to sign blank receipts for personal items that are purchased on the resident's behalf by administration. Interview with multiple residents on 11/20/12 indicated that they have never received a receipt for any item that is purchased and deducted from their account. Review of facility resident agreement identified that the residents are to give the rest home permission to assist with handling personal funds if they choose or are unable to unable manage them. Interview with the Administrator on 11/20/12 identified that the residents are not

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

given quarterly statements and the facility does not have a mechanism to be able to provide this for the residents.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D6 (b) Physical Plant (I) (2).

5. Based on observations during a tour of the facility and interview, the facility failed to provide storage to maintain the safety of the residents. The finding included:

a. Resident #17's room was occupied with several large containers-of personal items rendering it difficult to walk in the space provided for the resident, the resident sharing the room, and the staff. Interview with the Administrator on 11/22/12 at 10:00 AM identified the facility did not provide storage for Resident #17.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D6 (c) Administration (4) (A)(B)(C)(D).

6. Based on observations, and staff interviews, the facility failed to provide documentation indicating staff received orientation, and/or the facility had a written plan for continuing education and/or the staff received yearly continuing education.

a. Review of the staff files for LPN #2, #3, #4 and, #5 on 11/21/12 at 1:00 PM failed to identify an orientation program was documented included but not limited to safety and emergency procedures, the facility policies and resident rights.

b. Review of the facility policies, procedures and documentation failed to identify a written continuing education program had been developed for staff that included but was not limited to resident rights, behavioral management, personal care, nutrition, food safety, and health and safety in general.

c. Review of the staff files for LPN #1, #2, #3, #4 and #5 on 11/21/12 at 1:00 PM failed to identify continuing education was provided annually that included but was not limited to resident rights, behavioral management, personal care, nutrition, food safety, and health and safety in general.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D6 (c) Administration (5)(g), (h)(2) (5) General Conditions (2).

7. Based on observations, staff and resident interviews, the facility failed to ensure the health, comfort and safety of the residents at all times. The findings included:

a. Observation of the facility on 11/19/12, 11/20/12 and 11/21/12 identified the facility failed to provide routine recreational activities for the residents. Interview with the Administrator on 11/21/12 indicated recreational activities are not consistently provided to the residents of the facility due to staffing issues and the lack of finances.

b. Observation of the facility on 11/19/12, 11/20/12 and 11/21/12 identified the facility failed to allow residents to dine with family member and/or friends. Interview with the Administrator on 11/21/12 indicated the facility does not have room to allow residents to dine with anyone other than facility residents.

c. Interview with the Administrator of the facility on 11/21/12 identified residents who shared rooms with others resident were only allowed one television in the room.

d. Interview with the Administrator of the facility on 11/21/12 identified residents who drive and have vehicles at the facility were not allowed to drive with other residents.

e. Observation of the facility on 11/19/12, 11/20/12 and 11/21/12 identified male and female residents were segregated by gender in the dining and lounge areas. In addition the bedrooms were segregated by gender in separate hallways.

f. Observation of the facility on 11/19/12 identified only one telephone was available for the residents to use in an open lounge area that lacked privacy.

g. Interview with the Administrator on 11/20/12 identified the facility does not have a Resident Council or system of communication sufficient for the residents to discuss issues/living conditions and implement changes as needed.

h. Review of the clinical record identified on 7/16/12 Resident #13 was found running into the road and had become increasingly aggressive. Resident #13 was admitted to the hospital on 7/16/12 for a change in behavior with diagnoses that included psychosis, seizure disorder and mild mental retardation. Resident #13 was evaluated, treated by psychiatry, and sent back to the facility on 7/18/12. On 8/6/12 Resident #13 ran into the road again, was sent to the hospital for an evaluation and was subsequently transferred to a skilled nursing home. Interview with the Administrator on 11/21/12 indicated although Resident #13 was at risk for elopement interventions were not put in place to ensure the safety of Resident #13 when he/she returned from the hospital on 7/18/12.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13- D6 (c)

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Administration (5) (m) (E) Required Record (i) (ii) (iii) (F) (i) (ii)(iii)(iv) .

8. Based on an observation during a tour of the facility, a review of clinical records, staff interviews and a review of the facility policies and procedures, the facility failed to administer and/or store medications that reflected best practice. The findings included:

a. Observation of the facility on 11/19/12 identified the refrigerator used for insulin was left unlocked and not attended by staff at all times. Interview with LPN #1 on 11/19/12 at 11:00 AM indicated the staff members do not always lock the refrigerator so they have access to the medications quickly. Further interview with LPN #1 identified the refrigerator should be locked when it is not being used.

b. Interview with the facility Administrator on 11/21/12 identified she trained the staff to obtain blood glucose levels, however failed to document the training and ensure the training was a part of the staff member's personnel file.

c. Observation of Resident #9 and #17 on 11/22/12 identified Insulin and syringes were stored in the resident rooms for approved self -administration, however the syringes and Insulin were not secured. Interview with the Administrator on 11/22/12 indicated that Resident #9 and #17 would have to purchase their own lock box to secure Insulin and syringes in their room.

d. Observation of the nurse's station on 11/19/22 identified an Epinephrine pen 0.3 milligrams for Resident #15 was in the nurse's station, not secured and had expired on 8/12/12. Subsequent to the surveyors inquiry LPN #1 indicated she would order an Epinephrine pen and secure its storage.

e. Review of the controlled substance disposition record for Resident #9 directed the administration of Vicodin 5mg (milligram)/500mg as needed. The count was incorrect on 8/25/12. According to the narcotic record there should have been seventy nine tablets left in the blister pack, however seventy six tablets were recorded as being left. Interview and review of the controlled substance disposition record on 11/19/12 at 2:50 PM with LPN #1 indicated three Vicodin tablets were missing and she could not identify why. Further interview with LPN #1 identified narcotic counts were not always conducted and/or discrepancies were not corrected. Interview with the Administrator on 11/19/12 at 2:55 PM indicated two staff should be counting the medications together and rectify discrepancies on the same day. A review of the facility policies and procedures identified a process was not in place to count narcotics and/or a process by which to correct discrepancies.

f. Review of the controlled substance disposition record for Resident #1 directed the administration of Dilaudid 2mg as needed. Review of the narcotic sheet on 8/9/12 for Resident #1 identified eight Dilaudid 2mg tablets were recorded as being left in the blister pack. On 8/11/12 six tablets were removed from the original blister pack and placed in a locked box for the resident to administer if needed during the night. The medication was not returned and/or accounted for as being administered.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

g. Interview with the Administrator on 11/21/12 at 2:50 PM identified controlled substances are discarded by the nurse without a witness or signature of two people. Further interview with the Administrator indicated two staff members should be discarding the medication with both signatures on the controlled substance sheet that would remain a part of the resident's clinical record. Review of the facilities policies and procedures identified a process was not in place to discard controlled substances.

h. Review of the controlled substance record of Resident #9 identified eight Valium 5mg tablets were delivered to the facility. On 7/1/12 LPN #1 borrowed two tablets for another resident and indicated she discarded the other six as they had expired. LPN #1 identified she should not have borrowed Resident #9's medication. Interview with the Administrator on11/19/12 indicated she was aware that on occasions borrowing of medications occurred as the pharmacy did not always refill medications in a timely manner.

i. Interview with the Administrator on 11/21/12 at 2:30 PM identified she administered flu vaccines to staff members without a physician's order. The Administrator further indicated she utilized the remainder of the flu vaccine vial that was ordered from the pharmacy for the residents of the facility. Interview with Pharmacist #1 on 11/21/12 at 1:50 PM identified forty three residents where ordered flu vaccines on 10/8/12 and approximately seven doses were left to discard. The Pharmacist indicated the facility did not have orders to provide flu vaccines to the staff.

j. Review of the controlled substance disposition record for Resident #10 with LPN #1 on 11/19/12 at 2:10 PM identified Hydromet Syrup 170 milliliters was recorded as remaining. Observation of the Hydromet Syrup with LPN #1 indicated less than four ounces was left in the bottle. LPN #1 could not explain why the count was not correct.

k. Review of the controlled substance disposition record for Resident #11 with LPN #1 on 11/19/12 at 2:20 PM identified Cherratussin Syrup 45 milliliters was recorded as remaining. Observation of the Cherratussin Syrup with LPN #1 indicated less than one ounce was left in the bottle. LPN #1 could not explain why the count was not correct.